The use of counselling and leadership skills in cancer care

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Improving outcomes for patients is central to the delivery of cancer services. By focusing on improving the psychological well-being of patients it becomes very clear how important the link is between the appropriate use of counselling skills and effective nurse leadership.

The Manual of Cancer Services (Department of Health, 2004) is an integral part of The NHS Cancer Plan (DoH, 2000) and provides a mechanism by which cancer services can demonstrate that they are meeting the standards required of them. Its requirement for peer review (Box 1, p24) includes evidence that core nurse members of each site-specific multidisciplinary team (MDT) should achieve proven academic competency in counselling theory and skills. This qualification should be at least equivalent to 20 CAT (credit accumulation and transfer) points at degree level.

After acquiring these skills nurses will be able to use them, along with leadership skills, to empower and motivate other health professionals and improve their awareness of the importance of psychological well-being in order to improve outcomes for patients.

Counselling skills

Essential counselling skills include active listening, questioning, paralinguistics, reflection, summarising and paraphrasing. These should be supported by appropriate body language such as eye contact and gestures to indicate attentiveness and interest. It is also important to be aware of ‘blocking’ or ‘distancing’ techniques that can be used to avoid becoming involved (Faulkner, 1998). Self-awareness is vital for the successful use of counselling skills.

Previously nurse training in communication skills has been poor but there is now a greater awareness that senior nurses should receive appropriate training in communication skills to enable them to teach them to more junior colleagues (Fallowfield, 2001). However, while nurses have the opportunity to influence other professionals’ practice they should not have sole responsibility for improving psychological care.

Counselling skills such as listening and responding can be used at any time by all levels of staff (Faulkner and Maguire, 2001). They can enhance communication, caring and mutual respect between nurses and both their patients and their colleagues (Bumard, 1999).

However, nurses have traditionally seen themselves as providers of information and advice rather than as counsellors, focusing on their patients’ feelings (Burnard and Morrison, 1989).

Person-centred theory

Models of counselling are based on three main psychological theories: psychodynamic, behaviourist and humanistic. These complement each other and overlap, although one is often more appropriate than another in particular situations.

The person-centred model of counselling (Faulkner and Maguire, 2001) is recommended for use in clinical practice (NICE, 2004) and is forming the basis of a national education programme for senior medical clinicians. Its application in clinical practice...
is limited in that patients and relatives tend to expect information and help primarily with decision-making in acute hospital settings. The expectation is that health professionals will investigate, diagnose and treat their illness. It is likely that many patients will not want to be ‘counselling’ at a diagnostic point in their journey because their needs are more related to receiving support in a temporary period of distress. Therapeutic counselling would not be appropriate at this stage but health professionals need to be aware of its availability to ensure patients are referred on when it is indicated.

However, with the person-centred approach health professionals can use counselling skills to modify how they give information according to individual needs by paying attention to the patient’s reactions. This approach allows patients’ reactions to be explored, helping to achieve the best outcome for them by reinforcing their self-worth and helping to retain some control of their situation. It is also appropriate for use in encouraging user involvement in care delivery at strategic and operational levels.

**Practice implications**

It is vital that members of the MDT recognise both their abilities and limitations in relation to counselling. They should understand when it is appropriate, with the patient’s consent, to refer them to a more qualified counsellor, psychologist or psychiatrist for more advanced support (NICE, 2004).

Although their practice should follow the relevant guidelines and frameworks it is important to point out that when health professionals use counselling skills they do not have to be perfect. These skills will be effective as long as the professional is non-judgemental and can demonstrate empathy and genuineness (Rowland, 1993). However, from an ethical perspective health professionals must know their limitations and the power of their interactions with patients. These may not always have a positive effect if the skills are poor or used inappropriately (Ellis et al, 2003).

Using counselling skills in clinical practice will improve patient care (NICE, 2004) but not all health professionals will be inclined to engage in such interactions. They may not feel equipped to encourage patients to disclose problems and thus have to deal with a response of anger, guilt or hostility (Faulkner, 1998). Some may believe professionals should not encourage patients to share problems if nothing can be done about them, but while talking in itself may not solve problems it can often help to put them into perspective and may make them more manageable.

As the NHS becomes more person-centred, building services around the needs and wishes of its users, nurses’ counselling and leadership skills will be increasingly important.

**Conclusion**

The Manual of Cancer Standards (DoH, 2004) and Improving Outcomes Guidance (NICE, 2004) provide a useful, objective framework for the use of counselling skills. However, they require leadership skills if nurses are to educate, mentor, practise intuitively and supervise. Nurse leaders must also acknowledge the limitations of such guidelines by continuing to find innovative ways in which to apply them while encouraging reflective practice and self-awareness as ongoing processes.

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**REFERENCES**


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**BOX 1. AIM OF CANCER PEER REVIEW**

To improve care for people with cancer and their families by:

- Ensuring services are as safe as possible;
- Improving the quality and effectiveness of care;
- Improving the patient and carer experience;
- Undertaking independent, fair reviews of services;
- Providing development and learning for all involved;
- Encouraging the dissemination of good practice.

The clinical specialist role offers nurses the opportunity to keep patients informed and supported at all stages of the diagnostic process either by answering questions or explaining the reasons for delays (Jenkins, 2005). As such the core nurse member of the MDT will assume the role of key worker (DoH, 2004). A team where there is commitment to listening to and hearing what patients say will be more likely to ensure practice is based on patient need rather than on professional tradition or routine. However, this can only be achieved if the wider organisational structure and culture is supportive (Fallowfield, 1998). The recommendations by NICE (2004) provide an opportunity to encourage all senior members of medical staff to attend communication skills training. This is useful because it ensures no one will feel threatened by the suggestion that they may find extra training useful.

It is possible for senior nurses to function effectively on previous experience and common sense. However, they can achieve and maintain a higher level of professionalism when using counselling and leadership theory to underpin practice. The leadership qualities required to improve practice should be underpinned by the qualities of a good communicator. If these two sets of skills are combined it becomes possible to improve outcomes for patients both directly and indirectly.

**Conclusion**

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